

AUTHORIZATION FOR MEDICATION

Child's Full Name: _____

Name of Medication: _____

Prescription Number: _____

Time Medication is to be given: _____

(Medication will not be given on an "As Needed" basis, specifics must be provided)

Amount of Medication to be given: _____

Dates to be given: _____

(Not to exceed two weeks without a physician's statement)

PARENT'S SIGNATURE DATE

FOR CENTER USE (Reminder: document the reasons why medications are not given as parent requested i.e., child absent, medication not sent, child sleeping etc...)

DATE TIME GIVEN AMOUNT ANY ADVERSE REACTIONS ADMINISTERED BY

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

If noticeable, adverse reaction to medication, what action was taken? Describe:

Attention to Person Requesting Medication Be Dispensed:
Form must be completed in it's entirety before the center can dispense any medication